COLORADO
School Health Services Program

SCHOOL HEALTH SERVICES PROGRAM PROGRAM MANUAL

Section 7

Quality Assurance

The School Health Services Program is a joint effort between the Colorado Department of Education and Department of Health Care Policy and Financing.
www.cde.state.co.us
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Section 7: Quality Assurance

7.1 Record Keeping

Districts are required to maintain complete and legible records that document the direct medical or health-related services claimed through Medicaid and provided to or on behalf of a student under the School Health Services (SHS) Program are:

- Medically necessary (defined in **Section 1.2**);
- Consistent with the diagnosis and plan of treatment for the student's condition; and
- Consistent with professionally recognized standards of care.

Districts must maintain auditable records that will substantiate the claims and cost settlement reports submitted for reimbursement to the SHS Program, and on request, must make such records available to the Department of Health Care Policy and Financing (the Department) or its representatives. Records must be retained for a minimum of six years in order to comply with state/federal regulations and laws. If a district is part of an audit, then the district is required to keep records until the audit has been completed, which may be longer than six years.

For cost report and settlement purposes, district records must demonstrate the necessity, reasonableness and relationship of the costs for personnel, supplies and services to the provision of services. These records include, but are not limited to, all accounting ledgers, journals, invoices, purchase orders, vouchers, canceled checks, timecards, payrolls, mileage logs, flight logs, loan documents, insurance policies, asset records, inventory records, organizational charts, time studies, functional job descriptions, work papers used in the preparation of the cost report, trial balances and cost allocation spreadsheets.

For Medicaid claims, district records must contain the following information for each student:

- The name and title of the professional staff providing services and/or supervision.
- Complaint and symptoms, history, examination findings, diagnostic test results, assessments, clinical impression or diagnosis, plan of care, date and identity of the observer.
- Notice of referral for therapy services by a licensed physician or licensed practitioner of the healing arts (updated annually).
- An annual care/treatment plan that describes the goals/objectives and level of service needed.
- Each occurrence for the specific procedures or treatments performed, including the date, type, length and scope of professional services provided.
- Medications or other supplies.

- Student progress, response to and changes in treatment, and revision of diagnosis.
- A Targeted Case Management (TCM) specific care plan for TCM services.
- If a district fails to maintain supporting fiscal and clinical records the Department may deny the district's claims submissions and recoup any Medicaid payments already made to the district.

7.2 Training

Districts participating in the SHS Program are required by the Department to participate in initial and ongoing training events. Trainings include, but are not limited to, the following areas: Random Moment Time Study (RMTS), annual cost report, Medicaid Administrative Claiming (MAC) cost report, quarterly financial submissions, compliance information, process modifications, program updates, state/federal regulations or policies and RMTS Coordinator or participant roles.

The Department, in conjunction with the RMTS vendor, provide initial training for the district assigned RMTS Coordinators, which include an overview of the RMTS web-based system and information on how to access and input information into the system. All RMTS Coordinators are required to attend time study training to understand the purpose of the time study, the appropriate completion of the time study moment, the timeframes and deadlines for participation, and the importance of the RMTS Coordinators role to the success of the program.

Staff members participating in the SHS Program do not attend onsite trainings but receive information on the time study through an online tutorial within the RMTS system that contains information about the SHS Program, the participant's role in the program, as well as, how to complete a sampled moment in the system. A sampled staff member must visit the required screens prior to being able to complete their assigned moment.

In addition to the time study trainings, the Department and its vendor also offer comprehensive trainings on the annual cost report and MAC cost reports.

Annually, regional onsite trainings are held at various locations in Colorado and districts are required to attend this training event in person. Other training's occur through a web-based option (Webinar) which is an online presentation with live demonstrations. All training materials are accessible and posted on the Department's website.

Training materials can be found at: School Health Services Training Schedule

7.3 School Health Services (SHS) Reviews

The Department or its vendor conduct comprehensive reviews of the SHS Program to ensure compliance with regulations (refer to **Appendix A.3**) and accurate reporting of financial costs and claims submissions.

RMTS Reviews

In addition to the quality assurance measures described in **Section 3**, participation in the SHS Program requires that districts undergo periodic reviews to validate that staff included in the direct service and targeted case management cost pools are qualified health care professionals or qualified personnel and that all licensures, registrations or certifications for staff providing School Health Services are current. The Provider Qualification Reviews focus on whether participating districts are including staff on their staff rosters that meet the licensure and certification requirements for the program as defined in the Colorado State Plan. A Provider Qualification Review will be conducted on all participating districts at least once every three years.

Cost Report Reviews

Quality assurance reviews are performed on annual cost reports and quarterly financials submissions. These reviews ensure that submitted reports are complete, staff information is accurate and reported costs are reasonable.

The Department or its vendor also performs an annual in depth financial review on at least 50% of the annual cost reports submitted. Randomly selected entries on the cost report are reviewed and selected districts must provide financial documentation in support of those reported costs. Sampled districts are required to provide documentation of actual costs (in dollars) for each selected entry. Policies regarding benefits, salary percentages or other flat rates are not considered acceptable documentation. District must also provide support for general and statistical information, such as bus logs to support the one-way trip ratio numerator.

For detail behind the financial and statistical documentation requested for the reviews see **Section 5.4**.

Districts are subject to a periodic Medicaid Administrative Claiming (MAC) Quarterly Financial Compliance Review at least once every three years, to determine whether the district is maintaining all the necessary financial records to support costs reported for one quarter's MAC claim and resulting payment. Financial documentation (MUST be cash based) for selected participants on the staff roster for the quarter will be reviewed.

For detail behind the financial documentation requested for the reviews see **Section 6.7**.

Medicaid Management Information System (MMIS) Claims Program Reviews

Ongoing claims reviews are conducted on a monthly basis to ensure appropriate billing practices. A general checklist for Medicaid claims submissions followed by the claims reviewers is provided below. Areas of review, include but are not limited to, the following:

- Claimed/ Billed Rates
- Reimbursement Rates
- Dates of Service
- Coordination of Transportation Claims (with a direct medical or health-related Medicaid service by date of service)
- Procedure Codes and Modifiers

Onsite Program Reviews are conducted for at least 25% of participating districts each year. For onsite Program Reviews, a random sample of claims is selected from the MMIS claims database. Claims are selected by student-month, where one student-month consists of all claims for one student during one month of the fiscal year.

Sampled districts are required to provide internal records to support the selected claims including the following:

- Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP) Effective on Date of Service (including TCM care plan or health plan, if applicable)
- Attendance Record for the Date of Service
- Service Logs and/or Clinical Notes for the Date of Service
- Medicaid Consent Form

The district will be issued a Corrective Action Plan (CAP) should the Department find that the district is insufficiently following all program policies and procedures. Districts issued a CAP will be reviewed at minimum one year and a half later to ensure that all billing issues identified have since been addressed and resolved.

Quality Assurance Checklist for Medicaid Claims

- Is the service billed for one distinct date of service?
  - Billing multiple units for multiple dates of service (span billing) is not allowable.
- Is the number of units billed appropriate for the service?
  - Certain services (such as therapy evaluations) may only be billed one unit per session. Other services are billed on a timed basis. Refer to **Section 2** - Covered Services for appropriate billing units.
- For transportation claims, is there another claim for a school health service on the same date of service for the student?
  - Claiming specialized transportation through Medicaid on a date in which a student has not received a Medicaid school health service is not allowable. Refer to **Section 2.9** – Specialized Transportation, **Appendix A.5** – SHS Program Regulations and **Appendix A.7** for further clarification.

CO SHS Review Checklist and Matrix

There are currently five review types that each focus on a specific area of the program. To help clarify the expectations for each review type, a Review Checklist and Review Matrix has been created. The Review Checklist provides an overview of each review type and the documentation required for the review. The Review Matrix shows at a glance what documentation is required for each review and if it is a sample or all documentation for that category. The Review Checklist and Review Matrix can be found on the MCRCS and RMTS dashboards.

SHS - Review Overview

Review	Program Area	Review Schedule	District Selection	Sample Size
Desk review	Annual Cost report	Once a year after the certification of the annual cost report.	All districts will be reviewed every year.	Review of cost data entered in MCRCS for annual cost report.
Annual in Depth Financial Review	Annual Cost Report	Once a year after the certification of the annual cost report.	50% of participating districts will be selected each year.	Sample of payroll and other cost. All documentation for transportation and provider certification.
MMIS Program Review	Medicaid Billing	Twice a year once in the fall and again in the spring.	Districts will be reviewed every 2.5 years. CAP implementation will be reviewed 1.5 years after initial Program Review	Sample of 10 students who had MMIS claims.
Provider Qualification Review	RMTS Staff Roster	Three times a year in conjunction with staff roster certifications.	Districts will be reviewed once every three years.	Sample of 3, 6, or 10 participants on staff roster depending on district size.
MAC Quarterly Compliance Review	Quarterly Cost Report	Four times a year in conjunction with certification of quarterly cost reports.	Districts will be reviewed once every three years.	Sample of 3 or 6 participants on quarterly cost report depending on district size.